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ABSTRACT

This paper cites the incidence of substance abuse among individuals with physical disabilities, especially among students in postsecondary education. The paper notes that differences in drug use patterns depend on whether the disability is congenital or trauma-generated and describes differences in the type of abuse depending on whether the abuse problem came before the disability or vice versa. The accessibility of drugs, the atypical social experiences of individuals with disabilities, societal enabling and entitlement of drug use among persons with disabilities, and the lack of identification of substance abusers are discussed. Strategies to address substance abuse among persons with disabilities are identified, including professional and student education, screening programs, an intervention team approach, and support groups. The paper concludes by urging departments for disabled student services in postsecondary institutions to incorporate substance abuse policy and procedures into their spectrum of issues addressed. (JDD)

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SUBSTANCE ABUSE PREVENTION AND INTERVENTION FOR STUDENTS WITH PHYSICAL DISABILITIES

National Conference for The Association on Handicapped Students Service Programs in Post-Secondary Education

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In an office for disabled student services one student in five coming through the door is likely to be a substance abuser (Moore & Siegal, 1989). The use of drugs, including alcohol, by students with disabilities is at least equivalent to that of non-disabled students (Moore & Siegal, 1989; Dean et al., 1985). In addition, some disabled students abuse drugs far more frequently and far more dangerously than non-disabled students. This presentation will offer some suggestions on how and why to address substance abuse issues in a disabled student services office or an equivalent organization serving the disabled.

The Scope of the Problem

There is a substantial overlap between people who have a substance abuse problem and those with a disability label. There are approximately 20 million people in this country with substance abuse as a recurring problem in their life (N.I.A.A.A., 1990). There are estimated to be 43 million disabled Americans (LaPlante, 1988). This includes both transient and permanent disabilities, but with either form of disability, substance abuse can be a significant problem.

In our research, we have found that there is a 20-40% overlap between the categories of substance abuser and person with a disability. This represents between five and eight million Americans. Using the standard models for computing social impact in work dollars lost and health care costs, (e.g., Wisconsin, Minnesota and the Federal Government studies), we calculate that up to 80 billion dollars a year are lost or expended because people with disabilities are abusing alcohol and other drugs. These figures indicate the significance of this public health problem, but it has received very little public attention to date. I realize that this sounds inflated, but these figures actually are conservative.

Allow me to elaborate on the drug use patterns of college students with disabilities. We studied the drug use patterns of 57 orthopedically impaired college students at one university. These students were differentiated by whether they experience a congenital or trauma generated disability. Students with the congenital disability did not tend to drink much or use many medications. In effect, they don't party much at all! These students tend to be socially isolated to a greater degree.

On the other hand, the students with a trauma disability used more kinds of drugs and drank more frequently, and in higher quantity, than did non-disabled students. We conservatively estimated that 20% of the disabled

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students were problem users based on their scores on a problem use check list.

We asked these students if they felt more entitled to use drugs because of their disabilities. In the majority of cases, they responded in the negative. When asked if they had more to lose because of drug use, the majority of students acknowledged they are at a higher risk when using drugs. They were aware of this fact. But in spite of that, these students frequently encountered drug-related negative consequences. For example, students did not know what kinds of medications they were on. They could usually name the medication, but didn't know the drug class. They didn't know how that prescribed drug interacted with alcohol or other recreational drugs.

Among the students with disabilities, the factors that correlated most with drug use in our study were high thrill seeking scores and sexual activity level. Not sexual frustration, but sexual activity level. High thrill seeking also is the highest correlate of use for non-disabled college students. The disabled students didn't identify chronic pain as the reason for non-prescribed drug use. They indicated that "Because I'm a college student, that's why I party." These findings suggest that the drug use of students with disabilities is similar to all students, just more dangerous for a number of reasons.

The findings of that study corroborated Glass's (1981) observation about substance abuse and visual impairment. He contended there are two types of substance abuse problems with someone who is disabled--Type A and Type B. Type A is where the substance abuse comes before the disability, and in fact, may contribute to the disability. Among college students, I suspect this is your most problematic group. This is the group that is at highest risk for continuing problems, and they comprise perhaps 20% or more of the students with disabilities on your campus.

Type A users may be socially active or fluent. They get along well with people. There is likely to be a history of family of origin problems, and these problems could either be substance abuse or some other kind of difficulties that stressed the family environment. This person also is a high thrill seeker. In addition, he or she has had repeated substance abuse problems, but with no corresponding changes in drug use patterns. This person doesn't see sustaining a disability, getting in trouble, losing repeated attendant care, or flunking out as consequences that are worth quitting drug use over.

Type B individuals experience substance abuse following the disability onset. Medication or chronic pain can reinforce a lifestyle that depends or relies on drugs. In our society, it is incredibly easy to get drugs, especially if you are disabled. Poor psychological adjustment to a disability can increase drug use. If an individual is having difficulty accepting the altered self-perception and lifestyle that comes with a disability, that person is going to have more difficulty with substance abuse as well.

<u>Drugs are very accessible</u>. One of the individuals whom I have interviewed stated that she never had to leave her home to get any kind of prescribed drug. She had multiple doctors she could call and tell "God, I feel so bad, I can barely move. The pain is worse. Can you please increase the Percodan?" or "Could you give me some Demerol?" or "The Valiums aren't cutting it, could you up them to 10 milligrams?" The doctor feels fairly powerless, doesn't know what else to do, and agrees with the request. The prescription is called into the pharmacy, the pharmacy already has a medical card, so all drugs are paid for. The pharmacy delivers the prescription to her door, and she never had to leave the house to receive the drugs. Physicians are getting much better at monitoring this, but there still are ample opportunities to slip through the

system.

Unusual social experiences. For both Type A and B individuals, atypical social experiences also lead to problems. Some individuals exist in social groups that are very closed, isolated and unmonitored. The deaf community is an example. Some researchers believe that there are a great many problems with alcohol abuse among the deaf community. The problem is that this group is isolated, and normal consequences of confrontation don't occur. The same thing can be true if there is a group of disabled students living and socializing together in a college or university. There may be substance abuse that is undetected because it is occurring outside the usual systems of social monitoring.

Entitlement. "Entitlement" is a phrase or term that goes beyond enabling. Basically, this means that the disabled have a right to get high because they are "handicapped." "If I was handicapped, I'd feel miserable, and I'd get high too!" This kind of attitude pervades society, and professionals are not excluded. This is one issue of prejudice that must be confronted and overcome in order to deal with substance abuse issues among the disabled.

Lack of Identification is Biggest Problem

The greatest problem in this area at present is that people aren't identified as substance abusers when a disability is present. Identification of problems must increase, or people are going to continue suffering. For most of society, a disability is very visible, but substance abuse is not. When you're disabled, you can hide the normal consequences of substance abuse behind your disability and most people won't be the wiser.

Here is one classic example, but there are many to choose from. There is a gentleman in our community who has cerebral palsy. For many years, he had a serious drinking problem. He frequently drove while intoxicated, and he repeatedly got pulled over. When an officer would walk up for questioning, this man would respond with disability-affected speech. What is the officer to assume? This man never got arrested for DWI because the officers believed his disability created the bad driving. They didn't even bother to test him for alcohol level.

Another individual I know has presented to the emergency room with fever, very high blood pressure and other symptoms of hyperreflexia (distended bladder and autonomic nervous system problems which are very serious) on three different occasions. These were all alcohol or drug related, and yet that was not diagnosed by medical personnel. Disabilities can hide substance abuse in almost every setting. People either feel uninformed or uncomfortable with disability issues, and often they feel like they need to overcompensate in some way. Overcompensation leads to enabling substance abuse and hiding these problems.

Social Stigma Associated with Substance Abuse. At issue in identification of substance abuse among persons with disabilities is the concept of social stigma. Boros (1980/81) and others have stated that one reason it's hard to identify alcoholism in a deaf population is because of the stigma associated with being a drunk. There is already one label that is negative in a sense, and that individual doesn't want another.

For example, in a discussion with the President's Commission on Employment and People with Disabilities, we discussed how substance abuse contributes to unemployment in a significant way for disabled people. However, if the President's Committee would state that, they might be creating more stigma

with potential employers. These employers might be put off if they thought hiring someone with a disability might also entail a substance abuse problem as well. This quandary of social need versus social image faces many policy makers in the disability field.

Handicapism. "Handicapism" leads to societal enabling of drug use among persons with disabilities. An individual with a disability learns immediately, whether as a child or right after the disability occurs, that people are going to cut him or her breaks in certain situations simply because of the presence of the disability. It's as simple as that. As a disabled consumer, you have a choice of how to respond to that. The path of least resistance is to take advantage of it sometimes. When that occurs, it reinforces family, professionals, and the public to continue to do those things, and it is circularly reinforced. Unfortunately, substance abuse and taking advantage of other people's feelings go hand in hand.

Strategies To Address Substance Abuse Among Persons With Disabilities

Sometimes professionals are uncomfortable about addressing substance abuse issues. This is because they don't know what constitutes abuse and what is normal use. They think, "Why bring this up: why create all this turmoil? What happens if I get this person really angry at me, and it really doesn't accomplish anything? Maybe it's best that I wait for something else to happen, then I'll know." However, there are things that can be done, and we can classify these as primary, secondary and tertiary prevention.

Primary Prevention. "Primary" implies going in before the problem exists and conducting the prevention for the whole group. Education in substance abuse for all disabled students is important. This means educating students to the fact that they are more vulnerable than the non-disabled and there are some consequences if one is not aware of these things.

For example, one area of primary prevention is with medication use. Presently, rehabilitation programs turn over drug education to the nursing staff. The nurses outline what has been prescribed by the doctor, and they inform clients of how often to take their prescriptions. They may show a movie on medications with some comments regarding alcohol use and medication, but the information is general and often not repeated to enhance retention.

For most individuals, more information is necessary. They need to know what happens if they take phenobarbital or Valium and then to go out and party with friends. They need to know the potentiating effects of these drugs in combination. They need to know that even with two beers, some medications nearly can put them in a coma. They're not exposed to this information in a meaningful way until they get out and have the good fortune to meet other disabled peers.

Another activity falling under the rubric of primary prevention is professional education. We need to let professionals know that specific and sometimes dangerous substance abuse risks exist and how to identify them. Ultimately, we need to require this knowledge of those obtaining professional licenses to work with populations of disabled persons. For example, people receiving psychology or counseling licenses need to know about disabilities and substance abuse.

Orientations provided by disabled student service offices should include information specific to the risks involved with substance abuse and disability. Most programs have some kind of freshman or new student orientations. It is very important that substance use and abuse be covered in those orientations. Students need to know what the school policy is, and what the conse-

quences are for infractions. Beyond that, disabled students need to know what some of the other risk factors are, such as medication abuse and societal enabling.

Printed materials provided to students should include a written substance abuse policy. At the same time, inform students about resources that exist in this area. Our research indicates that disabled college students don't feel especially comfortable approaching many counseling services. They perceive the counseling staff as not understanding of disabilities. Therefore, it is important to identify substance abuse resources that are sound and people who are sensitive to disability. List those resources for students and have it readily available.

Secondary Prevention. Secondary prevention means targeting people who are at high risk for specific behaviors. One activity we can initiate is a screening policy. If an individual presents at a center or office with a certain kind of substance abuse profile, we should encourage her or him to take a screening instrument. For example, in persons with a spinal cord or brain injury trauma, about half of all these disabilities are alcohol or drug generated. These populations should have the availability of voluntary alcohol and drug abuse screening. This is not being done in rehabilitation, and these individuals are being short-changed in this process.

Selective screening should be considered for all disabled student services recipients. If someone comes to the attention of your office because of substance abuse behaviors, you can offer to provide or coordinate a voluntary assessment or screening to give them more information on potential risk. The way to frame this service is in the educational realm. If it is kept in the educational frame, you will be more likely to be able to get the individual into the interview. The Substance Abuse Resources for Disabled Individuals project which I direct will have manuals available in one year to assist with these types of services. These materials will be free or low cost.

Tertiary Prevention or Intervention. Tertiary prevention is oriented toward individuals who are in trouble. In these cases, we must establish mandatory consequences for certain problems. Something that professionals are very reluctant to do is not serve someone--especially discontinue services if a drug problem persists. But in fact, that's the best thing in some cases. Consider establishing policies that specify consequences for substance abuse. If the consumer chooses not to do anything about his/her condition, then discontinue ancillary services because those services will not be effectively utilized.

Take an intervention team approach. If you are going to initiate interventions, do your homework first. Involve people who are close to the situation. Consider bringing them together for a pre-intervention meeting, and in a sense, get the story straight. "Now, what were these symptoms? When did they show up? Who witnessed this? Is this verified? Is this documented? Is the family concerned? Would a family member be willing and able to come to this meeting?" When all of those things are discussed and understood, then it's possible to meet with that individual, confront him or her with the facts and say, "Here's our concern. Obviously we can't run your life, but we want to make this recommendation to you."

Support groups. One of the most important things you can do is establish support groups. There are people ready, willing, and wanting to attend support groups related to substance abuse. Sometimes, they will prefer to attend a group that is disability specific. However, it falls on us as professionals to get those support groups running.

Support groups are easy to start. All you need to do is list it in a few

newsletters, post it on a bulletin board, and one or a few people will show up. The trick is to keep the group going. One way to do that is to assign a staff member as a sponsor. A sponsor could do no more than open up the room, make sure things are accessible, sit there, and tell people when the next meeting will occur.

Conclusion

The impact of the Drugfree America policies and the A.D.A. of 1990 will encourage written substance abuse policies in all agencies serving the disabled. It's almost certain to impact departments for disabled student services, especially as we become more aware of the special risks for substance abuse that can co-exist with a disability. It is very much in the interest of your staff and students to incorporate substance abuse policy and procedures into your spectrum of issues which are addressed.

If your office does not take on this responsibility, it's unlikely that anyone else in the disabled student's environment will be capable of doing it for you. Your personnel are more capable than anyone else in your environment for sorting the realities of living with a disability from rationalizations for substance abuse. Your departmental response to this issue undoubtedly will save some academic and vocational careers. In some cases, it also will save lives.

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